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ABSTRACT

This paper discusses the effects of pretraining counseling clients for group therapy sessions. In an attempt to speed the group process and give maximum coverage to all college students requesting group therapy, pretraining experiences were given to members of three experimental groups and were compared to one control group. The experimental conditions were: (1) there was no active input from experimenter, and the group was left alone "to get to know one another"; (2) subjects listened to tapes which explained some of the goals of group therapy and were allowed to role-play; (3) structured T-group experiences were provided. The findings suggested, first, that the types of pretreatments employed were relatively ineffective in influencing the subsequent process in the groups. The interactions in the groups seemed to be much more highly influenced by the activity, or lack of it, on the part of the leader. More active leaders tended to have groups in which discussion centered on personal material, while less active leaders had groups in which discussion centered on impersonal topics. Groups which rated themselves as most improved tended to be those in which there was more discussion of personal feelings and where the leader was more active. (Author/PC)

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Influencing Interaction and Outcomes in Group Psychotherapy

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Let me start off by telling you something about our clinic. We have a Student Mental Health Clinic which is part of the Infirmary at the University of Connecticut. We see about a thousand patients a year, mostly undergraduates. We have 12 or 13 staff members, not all of them full time, and a number of graduate students in training. During the year, we run fifteen or sixteen therapy groups. The groups start at various points throughout the school year, and usually run until the end of the Spring semester, when most people leave for summer vacation. Because of this, our groups are necessarily time-limited. We began this study with the hope that we might do something to get our groups moving faster than they usually do. We thought this would be important because it would help everyone get the maximum benefit from the limited amount of therapy that was available. Our experience has been--I'm sure most of you are familiar with this process--that our groups sometimes met for several weeks in the beginning, dealing with issues of defensiveness-openness and how to handle that in the group, and this period really postponed the time when the group could settle down to begin working on the more personal issues people brought to the group.

The study includes nine groups, each run by two co-therapists who were members of our staff. There were 52 patients and 13 therapists in all. All but one of the groups had both men and women (one was all female). The median was six patients per group. The

groups were studied through the first ten meetings, and members were asked to make ratings on themselves at various points throughout. The first six group meetings were also tape-recorded, and I will say more about the tapes and the way we rated them in a moment.

We had four experimental conditions. In the control condition (2 groups), the group simply started meeting in the usual way, with the therapist present from the beginning.

Groups in the three experimental conditions received some kind of pre-training before meeting with the regular therapists. The group came to the clinic at the usual time, but instead of the therapist, they were met by one of the experimenters who explained the purposes of the experiment to them and gave them the pre-training. We told our subjects that we were interested in seeing if we could get the group started faster than usual, and that that was the purpose of the pre-training. Everyone agreed to participate.

There were three pre-training conditions. In our placebo control condition (2 groups), the experimenter left the group alone in the room for an hour. The only requirement was that they "get to know each other" and they had to spend the entire hour together--no one was to leave. At the end of the hour, the experimenter returned to tell the group the time was up. The experimenter was also supposed to check to be sure there were no negative reactions, but otherwise was not to involve himself in helping the group process what had happened. As far as we could tell,

there were no overtly negative reactions among these patients. This condition was designed as an "attention control" to control for the fact of coming to the clinic and meeting together as a group, but was not supposed to contain any "active" input from the experimenter.

The other two experimental conditions were designed to have positive effects, in addition to the more global placebo effects. In one condition we used a taped training procedure which had been developed in earlier research by Bernice Schaul and Anthony D'Augelli. In Schaul's research, she had found she could accelerate the interaction in laboratory groups by giving them specific training at the beginning. We used her cognitive-experiential training procedure, which was the one she had found to be the most effective of the three she tested. In this procedure, subjects listened to a tape which explained some of the goals of group therapy. The goals given were: 1) tuning in to one's feelings, 2) giving constructive feedback, and 3) self-disclosure. For each of the three, the announcer on the tape explained the meaning of the concept. Then a taped example from an actual group interaction was given, and following this there was a pause on the tape. During the pause, the subjects were to practice among themselves the particular activity which was explained. For example, in the first pause they were to say something about their here-and-now feelings, how they felt right at the moment, how they felt about being in the group, etc. The experimenter running the tape stopped the machine to allow the group time to finish, and then started it again for the next topic. Schaul had found that this training

procedure was superior to either cognitive instructions or experiential training alone in promoting subsequent non-defensive group interaction.

The last experimental condition required the patients to participate in a T-group experience, led by one of the experimenters (2 groups). In this condition, the group met at the regular time, and was introduced to the experiment by the experimenter. The experimenter then had the group perform a series of structured exercises. First they had a ten-minute warm-up period in which they did bodily relaxation exercises. Then the group divided themselves in half, into "more anxious" and "less anxious" sub-groups (self-selection). Dyads were formed, with one high-anxious, and one low-anxious member in each dyad. The dyads spent time together, trying to help one another relax and sharing their feelings with each other. Next the group was again divided in half (not the same halves), forming two concentric circles, and played "Magic Basket." In this exercise, the members in the outer circle observed one member of the inner circle. The members of the inner circle took turns. First they would go around the circle and each would put something in the "basket" that he wanted to get rid of. Then they went around again, this time taking something out of the "basket" they wanted to get, like self-confidence, being more out-going, etc. After this, the two circles switched, and the game was played again. In the last stage, the group was reformed and

spent about 15 minutes sharing their reactions and feelings about the experience.

In no case was the pre-training given by either of the group's prospective co-therapists. The groups in all three of the experimental conditions met for the first time with their regular therapists at the regular time the week following the pre-training. Although new patients were added to the groups to replace drop-outs, we are only reporting rating data from patients who participated in the pre-training.

We used two types of dependent measure. One was a shortened version of the Mooney Problem Checklist, which we had developed earlier (Piper, 1971; Piper, Wogan, and Getter, 1972). The first time the patient came to the group meeting (either pre-training or control), he went through the list of 140 problems. The first time he checked all those problems he thought applied to him, then he rated each item he had checked in terms of how much help he thought he would get from therapy for that particular item. The third time through, he rated each checked item in terms of how important he felt it was for him to solve that item.

Thereafter, the problem checklist was repeated for the first three group meetings, and then every second week through to the tenth meeting. Each time he took the test, the patient got a form which was specifically tailored to him. That is, the problems he had checked the first time were checked again on the form, and the form had his name on it. He was to go through and rate each item that was

checked two times. The first time he checked how much improvement he felt had occurred in that area, and then he went back and rated each problem again, this time in terms of how confident he felt about the way he was handling it. We thought that the "confidence" ratings would be a good way of measuring improvement, reasoning that you might still have problems, but you might get better at dealing with them during the course of therapy. This turned out not to be the case. The Confidence ratings were positively correlated with the Improvement ratings, but were related at only marginal levels to our other variables, and so are not going to be considered further here.

Our second source of data was the tape recordings of the first six group meetings. The pre-training sessions were not recorded, but we tried to record all of the first six regular therapy meetings of all the groups. Our thinking about this was that any effects of our pre-training procedures would probably show up in the early meetings of the groups (rather than later).

The tapes were rated, using the Group Interaction Profile, or GRIP, which was an interaction measure developed by Herb Getter, Paul Korn and Ken Anchor (Korn, 1970; Anchor, 1972). Earlier research (Korn, 1970; D'Augelli, Chinsky and Getter, in press) had found high inter-rater reliabilities for all the scoring categories, ranging from 82 to 92%. We trained two raters until they reached 90% agreement with standard training tapes and 85% agreement with each other. The tapes were rated by listening to successive 30-second segments, stopping the tape, and rating the segment in

terms of the predominant kind of interaction going on. The six rating categories were: 1) Silence: 2) Leader Dominated 3) Personal, Group Related; 4) Personal, Group Unrelated; 5) Impersonal, Group Related; 6) Impersonal, Group Unrelated. A total of 50 segments was rated from each tape. (Note that the scoring was ipsative--that is, any one segment could be counted in one and only one of the six scoring categories.)

Descriptions of the four content categories are as follows:

Personal, Group Related. Personal reactions to the leader expression of personal feelings about the group; expression of personal feelings about a silence; clarification or exploration by two or more members of their relationship, how they perceive each other, or what is occurring between them in the group.

Personal, Group Unrelated. References or description of personal experiences outside the group, including why he came to the group, personal goals, interests, where he lives now, his roommate, etc. reactions or advice-giving to another member dealing with group-unrelated material, e.g., "You ought to try being more honest with your mother."

Impersonal, Group Related. Remarks concerning procedure, including rules, structuring, purpose, terminology of the group. Comments regarding group process, e.g., "We seem to be avoiding each other." Remarks about the group leader in terms of his role, motives, training, or behavior as leader.

Impersonal, Group Unrelated. Discussion of general topics

not relating directly to the group members, e.g., Vietnam, religion, hippies, "friendship," fraternities, or hypothetical situations which do not include the group members directly.

I'll try to simplify our results by saying at the outset that we didn't find any very strong effects deriving from our pre-training. On most of our measures, the four experimental conditions came out about equal, including some tests of their ratings of improvement, and also in terms of the group interactions as rated on the tapes. One weak, but significant finding indicated that over the first three group meetings, rated mean Improvemtne in the group rose gradually, but it increased at about the same rate in all four of the experimental conditions. We also found that if we averaged together all the improvement ratings for the group, over all ten sessions, there was a small but significant conditions effect. The means are shown in the first slide (Table 1). The groups receiving the taped instructions showed the highest ratings, and the groups in the placebo control condition received the lowest on both the Improvement and Confidence measures.

Analyzing the tape ratings, we found there were no differences among the four experimental conditions during the first three sessions. Testing all the tapes available for each group (usually six sessions) there was ore significant finding. Lumping across all six sessions, we found there were significantly more silences in the T-group condition than in the other three conditions. The

means for silence are given in the next slide (Table 2).

The effects of our pre-training seemed to be very weak, but we noticed in scoring the tapes for the different groups that there seemed to be wide variations in the ways the groups were proceeding. Some groups seemed to be much more active than others, to be more revealing of personal material, and to be getting more done. It seemed like we were looking at our data from the wrong angle, and not really isolating the important factors which separated the groups from one another. One thing that seemed to be important was the therapist running the group, and to test this, we combined those groups that had the same senior co-therapist (but not always the same junior therapist). When we did this, we found we had strong positive effects on both the rating measures and the tapes.

For example, by grouping together the Improvement ratings over all the group sessions, we found there were clear differences in the overall outcomes obtained by the therapists. ($F = 4.44$, $p < .001$). The mean Improvement ratings are shown in the next slide (Table 3). Therapists 2 and 3 seem to have the poorest overall outcomes, and therapists 4 and 6 were the most successful.

The six GRIP variables were also analyzed for therapist effects, by combining all the tapes available from each group. Three of the six scoring categories, Leader Dominated: Personal, Group Related; and Impersonal, Group Unrelated showed significant therapist effects. ($F = 4.34$, $p < .01$ 4.53, $p < .01$ and 3.54, $p < .01$, respectively). The means on each of these variables for each of

the six therapists are given in the next slide (Table 4). Therapist 2, who was one with the poorest outcome ratings, showed a low level of Personal, Group Related content, and a high level of Impersonal, Group Unrelated content. He also showed a low level of Leader activity. Therapist 4, who was one of the more successful according to the patient outcome ratings showed a high level of Personal, Group Related activity, a very low level of Impersonal, Group Unrelated content, and a moderately high level of Leader activity.

To characterize the more and less successful groups more clearly, the groups were divided into high, medium, and low on the basis of the average Improvement rating in the group at the time of the final testing. There were three groups in each category. In forming the groups in this way, we found Therapists 1, 4, and 5 had groups in the High outcome category (therapists 4 and 6 also had high outcomes in the earlier analysis). Therapists 2 (2 groups) and 3 had groups in the Low outcome category (therapists 2 and 3 also had the poorest outcomes in the earlier analysis). We then analyzed the ratings on the six GRIP variables to compare the differences between the high and low outcome groups. All but one of the six categories proved to be significantly different between the high and low outcome groups, as shown in the next slide (Table 5). The high outcome groups were found to have more Personal, Group Related: Impersonal, Group Related, and Leader Dominated activity. Low outcome groups tended to have more Personal, Group Unrelated

activity, and more Impersonal, Group Unrelated. The level of silence in the two types of groups was not significantly different, but there was a trend in the direction of more silence in the low outcome groups.

The findings suggest, first, that the types of pre-treatments we employed were relatively ineffective in influencing the subsequent process in our groups. The interactions in the groups seemed to be much more highly influenced by the activity, or lack of it, on the part of the leader. More active leaders tended to have groups in which personal material was likely to be discussed. Less active therapists tended to have groups in which the discussion centered on more impersonal topics, and topics which were "outside" the group. Of course, we are making the assumption here that immediate, personal, group-related material is the most significant, but this assumption is supported both by our impressions of the groups in listening back over the tapes, and by the patients' ratings. Groups which rated themselves on the average as most improved tended to be groups in which there was more discussion of group-related material, particularly personal feelings, and where the leader was more active. Patients who rated themselves as less improved tended to come from groups in which the leaders were less active, and where there was more discussion of impersonal material, or of material that was personal but not directly connected to what was happening in the group (my roommate, girlfriend, etc.).

Just one further note. We should not leave you with the impression that all of these effects are due to the therapists. In the case of the mean Improvement ratings, some small effects were evident at the time of the first two group meetings, so there is a group-composition effect which is also operating. Our sample isn't large enough to bring this out clearly, however, and there isn't enough data available to do a complete analysis. To some extent there is probably also an interaction between therapist style and the membership of the group, but again we have too small an N of groups to be able to analyze for these effects. It would also be interesting at some point to examine the leader interventions of high- and low-outcome leaders to see if there are content differences in what the leaders say (not just how they say it, or how often they say it), but we have not done such an analysis.

It seems to us there is probably a minimal level of leader activity that is required in groups to foster interaction, particularly at the beginning of the group. We are reminded of the findings by Henry Lennard and Arnold Bernstein, who found with individual therapy cases that the most successful therapists were those who spent the most time at the beginning of therapy structuring the relationship and the therapy situation for their clients. It remains to be seen, once the therapist activity passes above this minimal level , which types of therapist interventions are the most successful, and we would like to suggest that this might be a fruitful area for future research.

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Experimental Design

Experimental Condition	Pre-Treatment	Treatment Sessions 1 2 3 4 5 6 7 8 9 10
Tape	Taped instructions*	
T-Group	T-group exercises*	
Placebo	Leaderless group*	
Control	-----	*

Tape-recorded →

*Form 1 of Problem Checklist

(Form 2 thereafter)

Table 1

Group Mean Improvement and Confidence Ratings,

by Treatment Conditions

Condition	Number of Groups	Number of Sessions	Improvement Rating		Confidence Rating	
			Mean	S.D.	Mean	S.D.
Tape	3	26	2.27	0.43	2.46	0.35
T-Group	2	18	2.04	0.38	2.34	0.28
Placebo	2	14	1.85	0.24	2.15	0.20
Control	2	15	2.03	0.46	2.34	0.33

Table 2

Degree of Silence in Recorded Sessions,

by Experimental Conditions

Condition	Number of Sessions	Number of Groups	Mean	S.D.
Tape	16	3	6.50	5.39
T-Group	12	2	16.83	8.16
Placebo	13	2	1.23	1.54
Control	14	2	5.57	5.77

Table 3

Mean Improvement Ratings, by Therapist

Therapist Number	Number of Groups	Number of Sessions	Mean	S.D.
1	2	14	2.11	0.40
2	3	26	1.99	0.35
3	1	7	1.67	0.24
4	1	10	2.35	0.23
5	1	8	2.16	0.64
6	1	8	2.27	0.39

Table 4

GRIP Ratings Across all Sessions, by Therapist

Therapist Number	Number of Groups	Number of Sessions	PGR Mean	PGR S.D.	IGU Mean	IGU S.D.	LED Mean	LED S.D.
1	2	12	14.33	8.52	12.33	11.62	15.50	5.73
2	3	19	10.84	9.96	17.16	11.53	6.95	7.10
3	1	8	20.25	11.54	4.50	4.37	7.00	5.01
4	1	5	34.40	15.84	2.80	4.38	12.80	5.93
5	1	8	18.25	9.81	7.37	3.96	10.62	5.32
6	1	3	12.00	8.00	14.67	7.02	2.67	4.62

Table 5

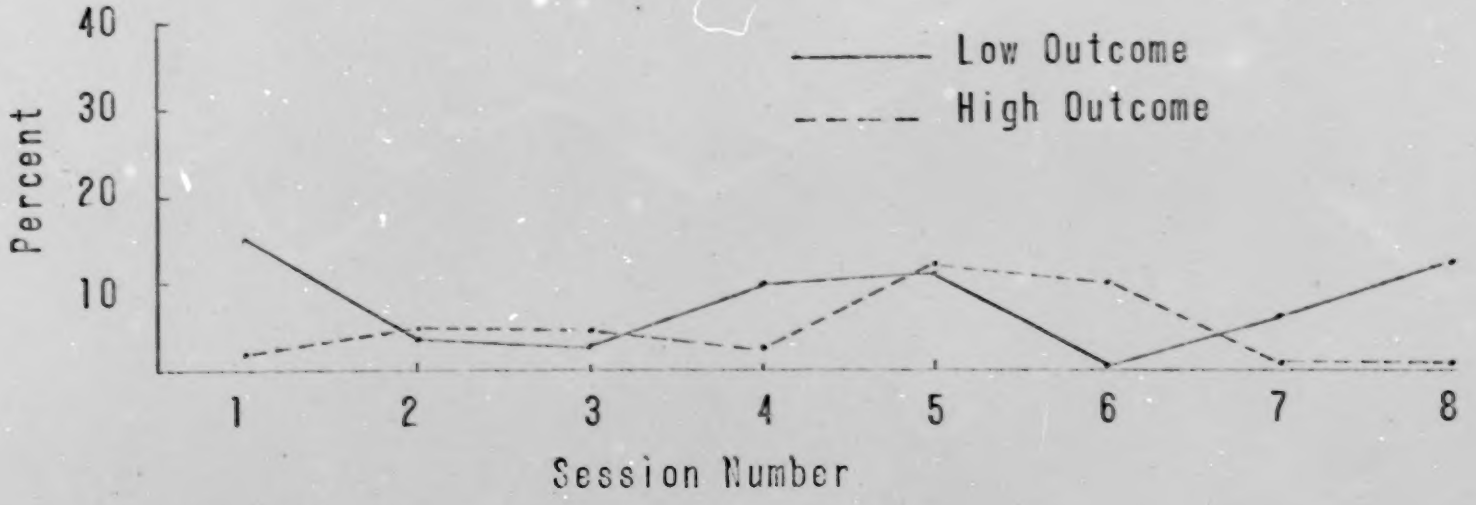
Mean GRIP Scores for High and Low

Outcome Groups

	High		Low			
GRIP Score	Mean	S.D.	Mean	S.D.	t	p
PGR	23.37	12.27	11.91	10.28	3.25	$<.01$
PGU	38.37	21.51	54.09	18.81	2.50	$<.02$
IGR	15.37	11.31	7.91	7.42	2.53	$<.02$
IGU	5.95	5.80	13.54	11.61	2.58	$<.02$
LED	12.05	5.19	4.64	3.97	5.18	$<.001$
SIL	4.95	5.59	8.00	8.92	1.29	n.s.

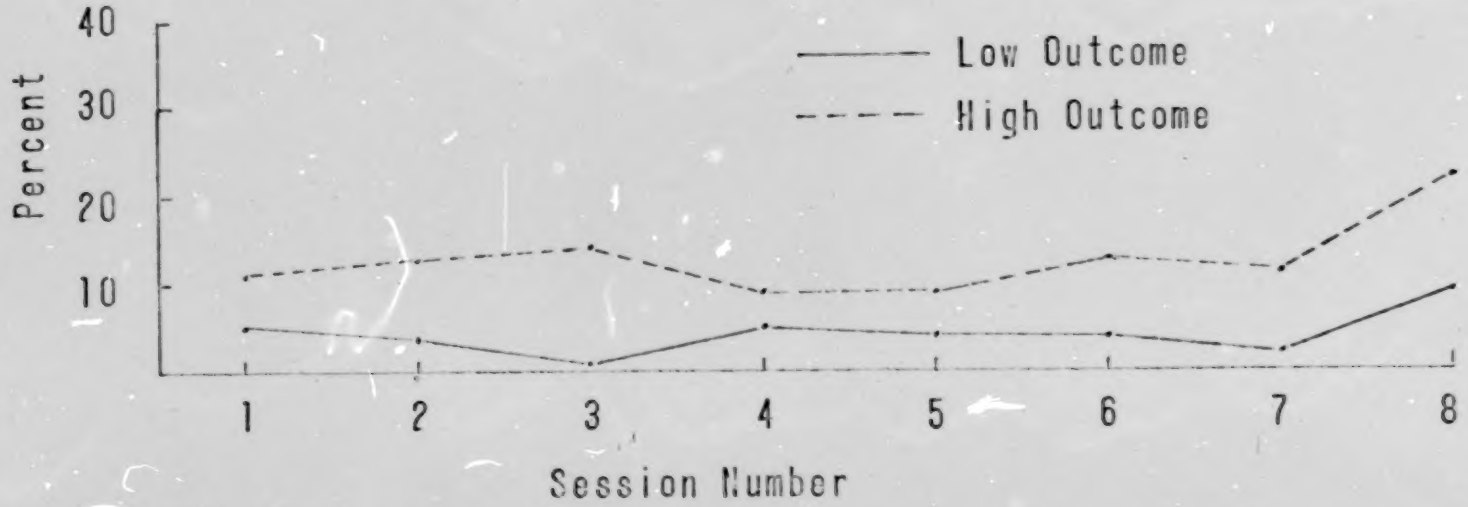
GROUP INTERACTION PROFILE:

Silence



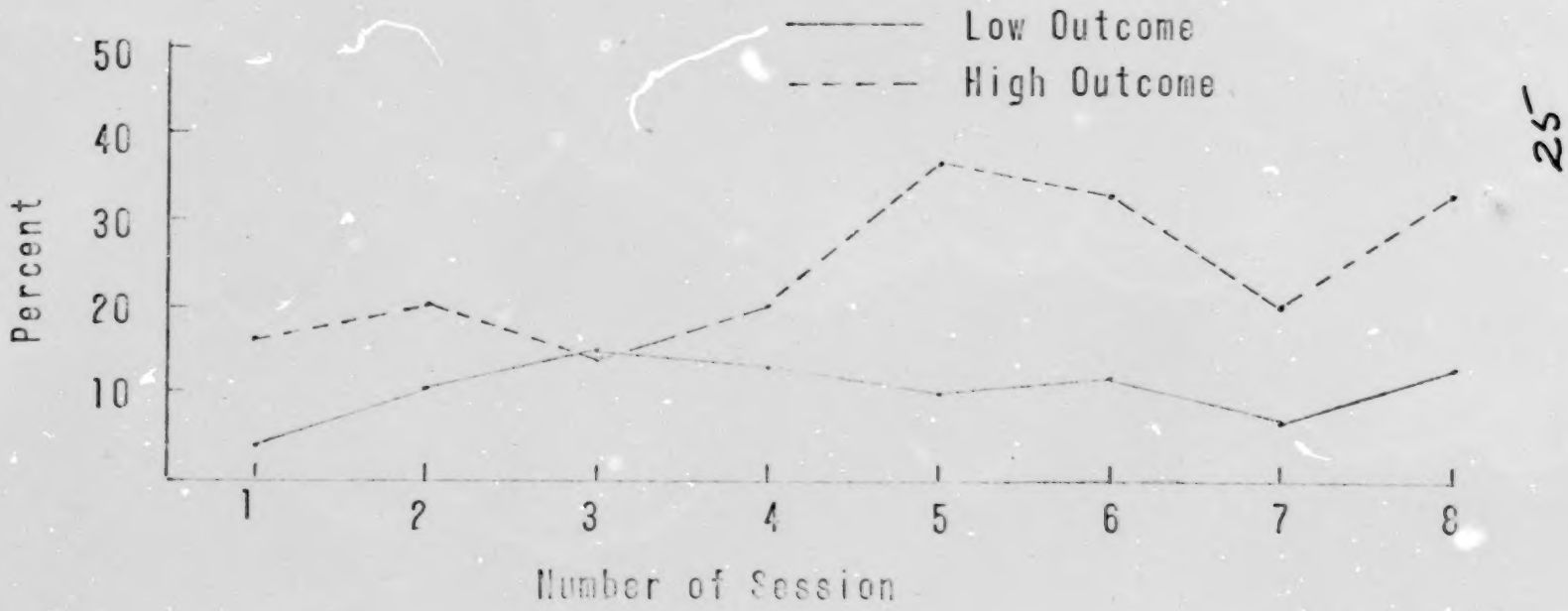
GROUP INTERACTION PROFILE:

Leader Dominated Content



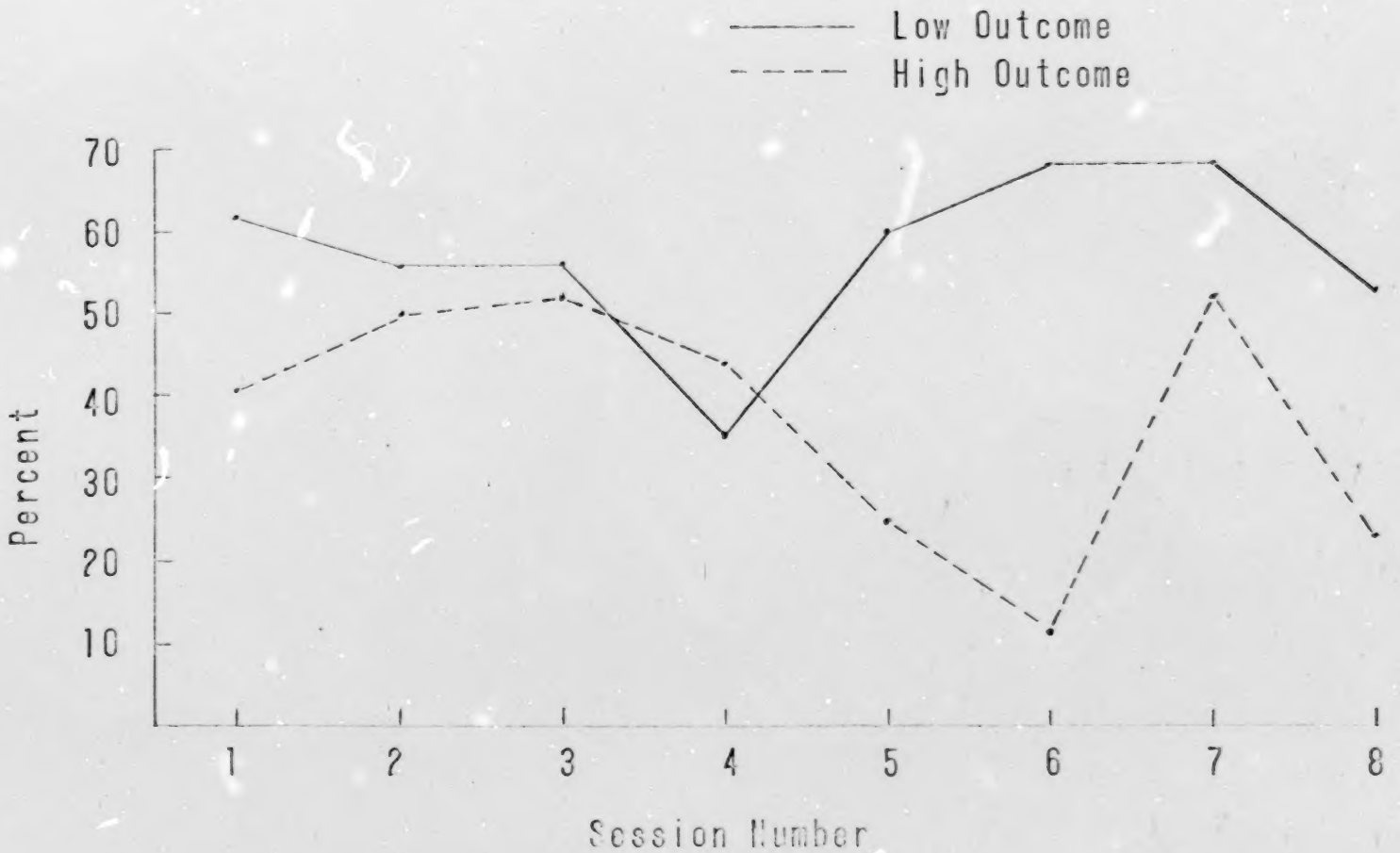
GROUP INTERACTION PROFILE:

Personal, Group-Related Content



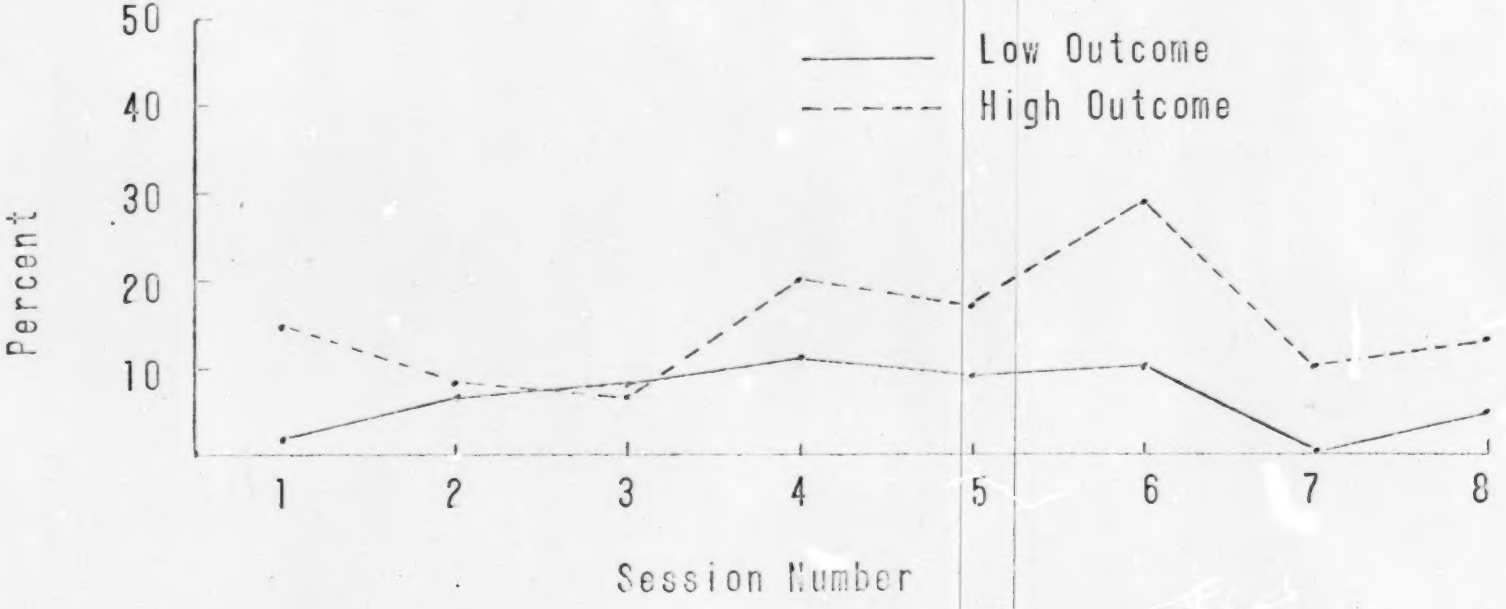
GROUP INTERACTION PROFILE:

Personal, Group-Unrelated Content



GROUP INTERACTION PROFILE:

Impersonal, Group-Related Content



GROUP INTERACTION PROFILE:

Impersonal, Group-Unrelated Content